GOVERNMENT OF ANDHRA PRADESH

A B S T R A C T

Convergence to improve Health and Nutrition Status of Women and Children - Interdepartmental Coordination for Effective Convergence – Launch of Maarpu Programme – Orders – Issued

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HEALTH, MEDICAL & FAMILY WELFARE (D2) DEPARTMENT

G.O.Ms.No.249 **Dated: 24-09-2012.**

Read the following:-

1) G.O.Ms. No.102, H.M. & F.W.(D2) Dept., dated 15-05-2012.
2) G.O.Rt.No.983, Planning (XVIII) Department, dated 23.08.2012.
3) SBCC Workshop held at IIHFW, Hyderabad on 6.09.2012.

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1. The efforts made by the Government of Andhra Pradesh over the past few years have resulted in improvement in the health and nutrition status of women and children. The Maternal Mortality Ratio (MMR – per 1,00,000 live births) has declined from 220 in 1997 (SRS 1997) to 134 in 2009 (SRS 2010) but remains much higher than the MMR of 81 in Kerala (SRS 2010). Similarly, the Infant Mortality Rate (IMR – per 1000 live births) has declined from 63 in 1997 (SRS 1997) to 46 in 2010 (SRS 2010) while Kerala has achieved a significantly lower IMR of 13 (SRS 2010). Further the percentage is still very high for (i) Low Birth Weight children at 19.4%, (ii) children (< 3yrs) who are underweight at 37% and (iii) Pregnant Women (15-49 yrs) who are anaemic at 56%(NFHS -3)

2. The current rate of decline in MMR & IMR is not up to the level expected and needs to improve significantly to achieve the MMR and IMR goals set as part of the Millennium Development Goals (MDGs). On the other hand Malnutrition is not only at unacceptable levels but is also a major underlying cause of maternal & infant deaths. **Hence, there is a sense of urgency to adopt strategies that can significantly improve the pace of decline of MMR, IMR and Malnutrition in Andhra Pradesh.**

3. In the GO first read above, operational guidelines were issued for institutionalization of Nutrition and Health Days and certain other areas of convergence. Vide reference 2nd read above, a Group of Secretaries (GoS) was constituted for convergence of Social Sector flagship programmes for improvement in Human Development Index (HDI) and achievement of Millennium Development Goals (MDG). The first meeting of the GoS, chaired by Chief Secretary was held on 16th August 2012. **It emerged that strengthening of health care services and nutritional services is very essential and equally necessary is behavioral change in the community** to tackle critical issues like age at marriage, early initiation of breast feeding, complementary feeding, high anemia levels, early registration of pregnancy, institutional deliveries, new born care etc. It was decided, inter-alia, that all the allied departments need to converge in order to have a synergistic effect and accelerate the improvement in the Maternal and Child Health and Nutrition indicators, and that a workshop would be held to work on the priorities and operational modalities.

4. The workshop was held on 6th September 2012 with various stakeholders to examine the existing convergence efforts and to identify areas in which cohesive and converged action could improve delivery and access to services and bring about behavioral change in the community. In the workshop and follow-up meetings, twenty interventions were identified, which have the highest potential of reducing MMR, IMR and Malnutrition. It was felt that the desired shift from programme-driven service delivery to demand driven mode would get an impetus through convergence efforts. The community would be involved not just in efforts to effect behavioral change but also in making the Health and Nutrition Plan for each village and monitoring the results using appropriate tools such as Quantified Participatory Assessment (QPA) to be sued by user group. The workshop recognized the strength of Self Help Groups (SHGs) that are universally present

across the State and are federated at the village, mandal and district level. It was felt that the District Collector must drive the convergence effort in the district with a suitable administrative structure to guide and support this initiative.

5. In view of the above circumstances Government has decided that the **convergence efforts would be taken forward through a programme named "*Maarpu*".** Various components of ***Maarpu*** are as follows:
   I. Focus on 20 key interventions to reduce MMR, IMR & Malnutrition.
   II. Convergence in Service Delivery at the habitation level.
   III. Convergent Behavioural Change Communication (BCC).
   IV. Monitoring of the 20 key interventions.
   V. Participation of SHGs & Village Organisations (VOs)
   VI. Use of Maternal and Child Protection (MCP) card.
   VII. Synchronization.
   VIII. Administrative Structures for convergence.

   Each component is detailed below.

6. **Focus on 20 key interventions to reduce MMR, IMR& Malnutrition.** The key interventions are as follows:
   1. ***Early Registration of Pregnancy.*** Registration to be done immediately on confirmation but definitely before 12 weeks of pregnancy and has the following components:
      a. A confirmatory pregnancy test
      b. Registration
      c. Issuance of Mother and Child Protection (MCP) card both in public & private sector.
   2. ***Ante Natal Checkups (ANCs).*** Every pregnant women to have minimum four ANCs of which, one between 16-20 weeks and the other between 32-34 weeks to be attended by the Medical Officer at the Primary Health Centers (PHCs) or as part of Fixed Day Health Services (FDHS). The components of the ANC are:
      a. Haemoglobin estimation (Sahli's method)
      b. B.P. measurement
      c. Urine testing
      d. Weight monitoring
      e. Tetanus Toxoid
      f. Distribution and ensuring consumption of Iron Folic Acid (IFA) tablets
      g. Updating the MCP card after each service delivery
      h. Health counseling, which includes awareness generation regarding general hygiene, exercise, diet, rest, breast care and danger signs during pregnancy.
   3. ***Maternal Nutrition.***
      a. Nutrition counseling be anchored by AWW with support of members of Village Health, Sanitation and Nutrition Committee (VHSNC) and particularly with help of ANM/ ASHA/SHGs/VOs. Focus will be on diet intake in terms of quantity and quality food with proteins and iron rich foods, and on consumption of IFA tablets.
      b. Diet supplementation at Anganwadi Center (AWC).
   4. ***Identification of high-risk pregnancies*** & ensuring appropriate referral.
   5. ***Birth Planning.*** Advanced birth planning for the pregnant woman is to be done with four components:
      a. Identification of the Institution where delivery is planned and to promote institutional deliveries at Public Health facilities (even if the delivery is planned in another village/town).
      b. Transport arrangements with 108 or any other alternative method.
      c. Identifying the person(s) accompanying the pregnant woman for delivery.
      d. Arrangements required for 48 hours stay at the hospital after delivery.
   6. ***Institutional delivery.*** Basic Services to be delivered for Intranatal care In Public & Private sector are

a. Quality of Intra natal care (Partogragh to be plotted for every delivery to know the course of parturition).
b. APGAR score of newborn and birth weight to be recorded in MCP card.
c. "Zero" doses of BCG, OPV and Hepatitis B and recorded in MCP card.
d. Issue of Birth certificate from MCP card.

In addition to the above services, Public Health facilities to

e. Make JSY payments before discharge.
f. Ensure safe drop back after 48-hour stay at the hospital.

7. ***Early initiation of breastfeeding*** (within an hour of birth). Counseling by Medical Officer or Health staff in case of institutional delivery and by AWW/ASHA/ANM during Home visits.
8. ***Exclusive breastfeeding for six months.*** Counseling of mothers at AWCs and during Home visits of AWW/ASHA/ANM.
9. ***Post Natal Care and Newborn Care.*** The Medical Officer to do the first postnatal visit at the hospital. The remaining six postnatal visits for the care of the mother & the newborn will to be done primarily by ASHA with support of AWW. ANM/Lady health supervisor/Medical officer shall be doing prioritized postnatal visits to high-risk cases, those that require special care, verify a sample of postnatal visits done by ASHA and provide on job training on post natal visits to ASHA. Apart from the examination the ASHA/AWW are required to:
    a. Identify signs of sickness in both mother and the newborn.
    b. Ensure appropriate, timely referral and inform the Medical Officer of the PHC to ensure that the Specialist/First Referral Unit (FRU) is ready to receive the patient.
10. ***Immunization.*** The infant gets zero dose of BCG, OPV and Hepatitis B at time of delivery; three doses each of DPT, OPV, Hepatitis B vaccines in sixth, tenth and fourteenth weeks after birth; Measles vaccine and Vit A after completion of nine months of age; DPT booster doses at 18 months and 60 months with biannual doses of Vit. A solution upto 60 months.
11. ***Growth Monitoring.***
    a. Regular growth monitoring by weighing all children below 5 years and plotting in MCP cards and growth registers of AWC through AWW/ANM.
    b. Immediate counseling of mothers & family members in case of faltering or decrease in weight of children using ready reckoner by AWW/ANM.
    c. Identify moderate & severe malnutrition and ensure nutritional counseling, supplementation and referral.
    d. Identification of Severe Acute Malnutrition (SAM), referral to Nutritional Rehabilitation Centers (NRCs) and follow-up.
12. ***Complementary feeding & Child Nutrition.***
    a. Counseling and Home visits for introducing complementary feeding at 7^{th} month and continued breast-feeding up to 2 years.
    b. Counseling on age specific quantity, quality and frequency of dietary intake for children (from 7^{th} month to 5 years) during NHDs, Home visits and Awareness Programmes.
    c. Supplementary nutrition at AWC.
13. ***Management of ARI & Diarrhoea.***
    a. Early identification of ARI & Diarrhoea
    b. Use of ORS & Zn for Diarrhoea
    c. Continued feeding during episodes of illness.
    d. Appropriate referral & follow up.
14. ***Strengthening of referral system.*** Establishing a referral linkage between community to health facilities and among health facilities. This will particularly include referrals for ARI, Diarhoea and other severe illnesses among infants and referrals for high-risk pregnancies.

15. ***Family Planning.***
    a. Delay in first pregnancy.
    b. Spacing methods after first delivery.
    c. Permanent methods with focus on Male sterilizations.
16. ***Maternal & Infant Death Reviews.***
    a. Improve reporting of Maternal deaths, Stillbirths& Infant deaths.
    b. Do Community Based Maternal Death Review & Facility Based Maternal Death Review.
    c. Review at district level with appropriate interventions to prevent such deaths in future.
17. ***Sanitation & Hygiene.***
    a. Counseling on Sanitation & Hygiene (Environmental & Personal)
    b. Hand washing practices
    c. Ensuring Cleaning of village water tanks & Chlorination of Water (Wells/Bore wells/Potable water)
    d. Use of Indian Sanitary Latrines (ISL) by households.
18. ***Age at Marriage.***
    a. Implementation of Prohibition of Child Marriage Act, 2006
    b. Awareness creation regarding the ill-effects of child marriage and legal provisions
19. ***Adolescent Girls.***
    a. Weekly Iron Folic Acid Tablet supplementation at schools and AWC.
    b. Nutrition and health education on lifecycle approach.
    c. Focus on school dropout's and vocational training
20. ***Gender Sensitization.*** Focus on
    a. Implementation of PC & PNDT act
    b. Sex Ratio
    c. Girl child education, trafficking and domestic violence

7. Convergence in Service Delivery at the habitation level.

Service delivery at the habitation level is to be converged and strengthened by having two Nutrition and Health Days (NHDs) at the Anganwadi Centre each month, instead of the one at present. In addition, Fixed Day Health Services (FDHS) shall be provided once a month at the sub-centre level. Home visits will be made separately and jointly. Details of services are as follows:

1. Out of the two NHDs, NHD-1 will focus on ANC services, immunization and counseling by the AWW with support of ANM, ASHA, members of VHSNC and particularly SHGs & VO.
2. The second NHD i.e. NHD-2 will focus on growth monitoring and counseling, wherein the ANM may not be present but the ASHA, members of VHSNC and particularly SHGs and VO will support the AWW. The ASHA/SHGs/VO will be responsible for mobilizing the user group and will actively contribute to the successful conduct of NHDs and FDHS.
3. The FDHS will be provided by the Medical Officer (MO) using a 104 vehicle. Pharmacist and Lab Technician will also be present for FDHS. The MO will provide the 2nd and 4th ANC to all pregnant women and identify the high-risk pregnancies. The MO shall also examine the malnourished and sick children during FDHS. He will refer the high-risk pregnancy and SAM children for specialized care.
4. Home visits as prioritized will be made by AWW/ASHA/ANM. During these visits the functionaries will involve members of VHNSC and particularly the SHGs/VOs.

8. Convergent Behavioral Change Communication (BCC).

Critical aspects for achieving results are community mobilization; counseling on health, nutrition and sanitation. IEC campaigns and demand creation all of which leads to Behavioral Change. This behavioral change will be achieved by:

1. Weeklong IEC campaigns called "***Mahila Sishu Chaitanyams***" to be held once in three months with focus on messages and themes based on 20 key interventions.
2. Coordinated counseling during NHDs anchored by AWW and supported by the ANM, ASHA, SHGs and VOs.
3. Counseling during Home visits by the AWW/ASHA/ANM/SHGs/VOs

4. SERP conducting annual awareness & training programmes for SHGs and VOs on Health & Nutrition.

9. Monitoring of the 20 key interventions.

1. This will be done by the Convergence Committees at all levels and the district level report will be sent to the Commissioner, Health & Family Welfare for review by the State Level Convergence Committee. Formats will be prescribed for monitoring and these will include those indicators, which are relevant in the present context and have the maximum impact for reducing MMR, IMR and Malnutrition.
2. Monitoring will also be done by involving the community particularly the SHGs and VOs using appropriate tools.

10. Participation of SHGs & VOs: The SHGs/VOs will play a key role in

1. Bringing about behavioral change in the community in the following areas.
    1. Age at marriage.
    2. Early registration of pregnancy.
    3. Promoting the use of MCP card
    4. To avail two ANCs by Medical Officer.
    5. Recommended dietary habits for pregnant & lactating women.
    6. Institutional deliveries and 48 hours stay in hospital.
    7. Newborn care including prevention of hypothermia.
    8. Early initiation of breast-feeding.
    9. Immunization
    10. Growth monitoring
    11. Complementary feeding.
    12. Community actions on anemia
    13. Personal Hygiene & Sanitation
    14. Eliminate gender selection.
    15. Active participation of community in NHDs, FDHS and Referrals.

2. Preparing Village Health and Nutrition Plans along with the functionaries from health dept. (ANM), WD&CW (AWW), PRI, RWS dept functionaries and members of the VHSNC. The necessary appropriate participatory tools will be prepared jointly by SERP, Health dept. and other concerned departments.
3. Adopting social audit and appropriate monitoring tools to assess the responsiveness of the public health & nutrition systems and to monitor the behavioral outcomes of community.
4. Being in the forefront for mobilizing the user group in successful conduct of NHDs FDHS, referrals and also participate in home visits.
5. Facilitating the efforts for BCC towards maternal and child health care.
6. Helping in service delivery to ensure quality and access of services.

11. Use of Maternal and Child Protection (MCP) card

The MCP card is a very powerful convergent tool. The MCP card covers all components required for delivering quality MCH care like antenatal services, delivery details, postnatal care, new born care, immunization, growth monitoring, recognizing danger signs during natal care, monetary entitlements, birth certificate and IEC material on nutrition. There is an urgent need to internalize the use of MCP card by all concerned departments. Extensive training, discussion and review under the guidance of District Collector will help to internalize the use of the MCP card.

12. Synchronization

There will be both Geographical and Functional synchronization. Geographical synchronization will be achieved through alignment of jurisdiction and service areas of functionaries of the allied departments at all levels, using GIS data. Functional synchronization will be achieved through service synchronization, training, data capture & utilization and joint monitoring.

The allied departments (Health & Family Welfare, Women Children, Disabled & Senior Citizens and Rural Development) are currently adopting different mechanisms and means for collection of data on the Mother and Child beneficiaries, with some common variables and a few specific variables for each department. It is decided to have a common database of beneficiaries as a part of a harmonized MIS from which each of the departments can access the information of the beneficiary.

13. **Administrative Structures for convergence**

The following Committees will be set up at various levels for monitoring and implementing the convergence efforts.

1. **State Level Convergence Committee:** This will have Chief Secretary as Chairperson; Principal Secretaries / Secretaries of Health, Medical and Family Welfare, Women Children, Disabled & Senior Citizens, Rural Development, Panchayati Raj, Rural Water Supply and Sanitation, School Education and Planning as Members; Commissioner (Health & Family Welfare) as Member-Convener; Commissioner (Women Development & Child Welfare), CEO (SERP) and Mission Director (NRHM) as Members & Co-conveners.
2. **District Level Convergence Committee:** This will have District Collector as Chairperson; Joint Collector, Cluster Convergence Officers (they will be District Officers identified by District Collectors), DCHS, Medical superintendent of teaching hospitals, PO (RVM), CEO (ZP), SE (PR), SE (RWS) and representatives of Zilla Mahila Samakhyaas (ZMS) as Members; DM&HO as Member-Convener; PD (ICDS) and PD (DRDA)as Members &Co-conveners.
3. **Cluster Level Convergence Committee:** This will be constituted at the level of the Community Health & Nutrition Cluster level and will have Cluster Convergence Officer (CCO) as Chairperson; Medical Officers (PHCs), Supervisors (ICDS), Cluster Co-coordinators (SERP) and representatives of Mandal Mahila Samakhyas (MSS) as Members; SPHO as Member-Convener; CDPO and Area Coordinators (SERP) as Members & Co-conveners.
4. **Village Level Convergence Committee:** This will be the Village Health, Sanitation & Nutrition Committee (VHSNC) as prescribed by GOI. This will have Sarpanch as Chairperson; all SC/ST/women ward members, any women MPTC member/ZPTC member/MPP President living in the village, president of village education committee, ANM, AWW, ASHA as Members and VOs as Member Conveners.

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14. **In order to operationalize the process of convergence through "*MAARPU*" and actively engage all the stakeholders in the process, the District Collectors are requested to convene district level workshops and disseminate the objectives and the key interventions of the Programme. Thereafter the above Committees will meet once in a month and review the implementation of "*Maarpu*" and progress of key interventions and the behavioral change. The committee can invite NGOs and experts to their meetings.**

15. **The concerned departments will also supplement the efforts of "*Maarpu"* by ensuring universal availability of quality services and improving their Programme designs. To support "Maarpu" guidelines on ICT, training etc. will be issued separately.**

16. **This order is issued in consultation with Department for WCD&SC, Planning Department, and Rural Development Department.**

(BY ORDER AND IN THE NAME OF THE GOVERNOR OF ANDHRA PRADESH)

MINNIE MATHEW
CHIEF SECRETARY TO GOVERNMENT

To
The Commissioner, Health & Family Welfare, A.P. Hyderabad
The Mission Director, NRHM, A.P. Hyderabad
The WD&CW Dept., A.P. Secretariat
The PR & RD Dept., A.P. Secretariat
The RWS Dept., A.P. Secretariat
The Rural Development Dept., A.P. Secretariat
The Tribal welfare Dept., A.P. Secretariat

All HODs under the control of HM&FW Dept.,
All the District Collectors & Magistrates
The CEO – SERP, Hyderabad
The Commr, PR, Hyderabad
The Director, Women Development and Child Welfare, Hyderabad
The Commissioner, Rural Development, Hyderabad
The Commissioner, Tribal welfare, Hyderabad
The Chief Engineer, RWS, Hyderabad
All DM&HOs in the state
All Regional Directors of Medical and Health Services in the State
All Regional Directors, WD&CW Agency
All Project Directors, WD&CW Agency
All RDO's / Sub Collectors

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P.S. to Minister for Rural Development, NREGS
P.S. to Minister for Panchayat Raj & Rural Water Supply

/Forwarded::By order/

Section Officer